INTRODUCTION

Mr. Chairman, I am very pleased to be here today. I would like to describe how the Health Care Financing Administration (HCFA) is working to ensure that the availability of managed care options will enhance health care for Medicare beneficiaries. It is important that we clearly define and support measures to promote quality of care, not only for beneficiaries enrolled in Medicare managed care plans, but for all Americans in all types of health plans.

Managed care options have been a part of Medicare since the program's inception. With the signing of the first risk contracts authorized under the Tax Equity and Fiscal Responsibility Act in 1985, managed care plans proliferated and today have become an essential part of the Medicare and Medicaid programs. As of January 1, more than 4.9 million beneficiaries have enrolled in 350 Medicare managed care plans, two thirds of which are risk contractors. Risk plan enrollment for the first six months of 1996 increased by more than 520,000 beneficiaries -- an annual growth rate of more than 30%. This increase is consistent with the rapid rate of program growth in recent years. In 1994, enrollment grew by 25 percent, in 1995, the growth was 36 percent. Medicaid enrollment has shown an even more dramatic increase, with a hefty 51 percent increase in 1995. Currently, almost 13.7 million Medicaid beneficiaries are enrolled in managed care plans.

In a managed care plan, a network of doctors, hospitals, skilled nursing facilities and other providers offers comprehensive, coordinated medical services to plan members on a prepaid basis. Except in emergencies, services must be obtained from health care providers that are part of the plan. Care may be provided at a central facility or in the private practice offices of the doctors and other professionals affiliated with the plan.

We have found that the managed care option is attractive to many beneficiaries. In many cases, enrollees can receive the same financial protection afforded by Medicare supplemental -- or "Medigap" -- policies without paying a premium. In addition, most plans provide benefits not covered under the Medicare program, such as routine vision care, dental care, and prescription drugs, at little or no additional cost to the beneficiary. I should point out, however, that the ability of managed care plans to provide additional benefits is due in part to the inadequacy of Medicare's payment methodology, which we have proposed to address in this year's budget. Beyond value measured in dollars and cents, managed care plans have the potential to provide value that can be achieved when services are coordinated and when the focus of care is on prevention and "wellness."

Our mission in HCFA is to serve our Medicare and Medicaid beneficiaries. Under this Administration, HCFA's efforts are firmly focused on obtaining the best value for our beneficiaries. We work in partnership with managed care plans in this task, but as I will describe later in my testimony, we have not hesitated to take enforcement actions when warranted.

BENEFICIARY PROTECTIONS

Current law provides beneficiaries enrolling in managed care plans a wide variety of protections, many of which are not received by most commercial enrollees. Let me take this opportunity to outline briefly the protections that beneficiaries enjoy under current law and areas where improvements are warranted.

- **Beneficiaries must receive clear and accurate information about the implications of their choice of a managed care option** -- Current law requires that plans provide certain information to all prospective enrollees including explanations of benefits, premiums and cost-sharing, lock-in requirement, and grievance mechanisms. However, we believe that more needs to be done to educate consumers about their health care alternatives and later in my testimony I will describe our plans for improvement in this area.

- **Beneficiaries cannot be subjected to health screening or preexisting condition limitations** -- Current law is clear in this area. We enforce this requirement through careful monitoring of all marketing materials and activities of contracting plans, and by reviewing beneficiary grievances and appeals.

- **Beneficiaries must have access to medically necessary and appropriate care** -- Before receiving a contract, all plans must meet Federal standards which guarantee beneficiary access to medically necessary services. HCFA is committed to ensuring that HMOs adhere to these Federal standards.

- **Beneficiaries must have access to procedures to resolve grievances and access to a neutral third party for appeals** -- While this is one area where Medicare's protections are significantly beyond those generally available to managed care enrollees in the private sector, we believe that improvements are necessary. Our plans for achieving these improvements will be explained in a subsequent section.

- **Beneficiaries' care is reviewed both internally and externally** -- Plans must have internal quality review mechanisms in order to receive a contract. PROs are responsible for external quality review. We have been working closely with other payers and the industry to make significant improvements in this area and, later in my testimony, I will outline these initiatives.

- **Beneficiaries are protected from the risk of discontinuous or inappropriate care that could result from the financial instability of a plan** -- Under current law, plans must be fiscally sound and must have a plan for protecting beneficiaries in the event of insolvency.

- **Beneficiaries' out-of-pocket expenses are limited** -- Under current law, Medicare managed care plan enrollees are protected by limits on premiums and cost-sharing and by prohibitions against balance billing.

We have also been working toward enhancing beneficiary protections. Some steps can be taken under current law, while other actions would require legislation.

- **Improving the Appeals and Grievance Processes**: The appeals and grievance process serves as a check and balance on contracting plans and helps to ensure that beneficiaries obtain all appropriate and medically necessary services. Improvement activities include an expedited appeals process for certain time-sensitive situations, shortened time frames for all other reviews involving service denials and terminations, and improved health plan accountability on the results of appeals and grievances. However, we cannot afford to be complacent in the face of recently publicized concerns, and streamlining the appeals process is one of our highest priorities.

- **Unrestricted Medical Communication**: The Medicare statute requires that contracting health plans must make all covered services available and accessible to each beneficiary as determined by the individual's medical condition. In fee-for-service, Medicare beneficiaries are made aware of the full range of treatment options by their physicians. Managed care enrollees are entitled to the same advise and consultation. This is a basic right of the patient and we have communicated the prohibition against "gag" provisions in a policy instruction to all health plans.

- **Post-Breast Cancer Surgery Hospitalization**: The national attention given to coverage of mastectomies indicates that there is a need for greater oversight. We are committed to preventing sub-standard care in this area since Medicare pays for one-third of all mastectomies. By law, Medicare beneficiaries who receive mastectomies are entitled to coverage for all medically necessary care. The decisions about what is medically necessary should be made by a woman and her doctor. To emphasize this, on February 12, 1997, we sent a policy letter to all managed care plans, making it clear that they may <u>not</u> set ceilings for inpatient hospital treatment or requirements for outpatient treatment. Similarly, we will soon be reinforcing this message in Medicare's fee-for-service sector.

- **Physician Incentive Plans**: Effective January 1, 1997, the Physician Incentive Plan Final Rule required managed care plans with Medicare or Medicaid contracts to disclose information about their physician incentive plans to HCFA or the State Medicaid agencies, <u>before</u> a new or renewed contract receives final approval. Plans whose compensation arrangements place physicians or physician groups at substantial financial risk must provide adequate stop-loss protection and conduct beneficiary surveys.

- **Prudent Layperson**: The Administration's plan clarifies the obligation of Medicare managed care plans to pay for emergency services rendered to their enrolles. By using HCFA's definition of "emergency services" as those services that a "prudent layperson" would reasonably believe to be needed immediately to prevent serious harm to the patient, States will be better able to determine similar requirements for commercial managed care enrollees.

- **National Marketing Guidelines**: To ensure uniform interpretation and provide beneficiaries with accurate and clear information about managed care plans, we have developed the Medicare Managed Care National Marketing Guidelines. These Guidelines, which will be released next month, were developed in cooperation with the American Association of Health Plans and representatives of the health care industry.

- **Beneficiary Information Publications**: HCFA and its Department of Health and Human Services (DHHS) partner agencies have developed several publications to inform Medicare beneficiaries of their rights and options. These beneficiary advisory publications answer frequently-asked questions about HMO enrollment and disenrollment, potential fraud and abuse, and the appeals process. Also, the latest edition of the Medicare Handbook was sent to all 37 million Medicare beneficiaries and it is our goal that all beneficiaries receive an updated handbook every year.

- **Comparative Information**: We want to provide all Medicare beneficiaries comparative information that would assist them in making choices. In the President's FY 98 Budget Plan, we propose that comprehensive comparative information on all plan options, including Medigap, be provided to Medicare beneficiaries and be funded by the plans. In the interim, we are working on making comparative information available on the Internet and to beneficiary insurance counseling centers. Phase I of this project will be available by June 1997, and will provide comparative market data about HMO benefits, premiums, and cost-sharing requirements. Currently, many of HCFA's regional offices sponsor and disseminate comparative information for local beneficiaries. HCFA is currently working to implement a Competitive Pricing Demonstration in Denver to test a range of new education and information resources for beneficiaries --- including new formats of printed materials, in-person seminars, and a 1-800 call center, all coordinated by a HCFA-sponsored third party. The goal of these resources is to help beneficiaries understand their options under Medicare and help them make the best choices --- whether it is fee-for-service, Medigap, or managed care.

- **Community-based Medicare Information Resource**: This past October marked the opening of a pilot project to provide beneficiaries with the latest Medicare information in a convenient, one-stop, personal service facility. The test site for "Your Medicare Center" is a Philadelphia shopping mall and is staffed by HCFA employees who explain managed care options, resolve concerns, and correct records. This innovative project will allow the public's concerns about entitlement, managed care choices and enrollment, Medigap insurance, coverage, premiums, and appeals to be answered promptly and efficiently. Additional services including educational seminars on managed care-related issues and health screening will also available, using technology such as interactive video-conferencing and computerized information kiosks.

IMPROVED MONITORING AND ENFORCEMENT

All of the beneficiary protections that I have just outlined are only words on paper unless there is an explicit commitment to enforcement. I am proud to say that this Administration has fostered significant improvements in oversight and monitoring of managed care plans. We have initiated a program of special investigations that may target a specific compliance problem, or review all plans in a heavily saturated market area. Protocol-monitoring processes have been revised to improve clarity and establish more consistency in the methods used to evaluate contractor operations. National guidelines for marketing materials have been developed to improve our monitoring of plan compliance with statutory and regulatory requirements.

For the first time in the history of the program, we have begun to impose intermediate sanctions in response to certain plan activities. If we find the same compliance problem in successive monitoring reviews, we are no longer treating the recurrence as an isolated event, but instead are taking enforcement actions. Under these sanctions, we can require a contracting organization to suspend marketing activities or enrollment of new members; in some circumstances we will suspend payments to the plan for new enrollees.

Finally, in regard to monitoring and enforcement, we also have several activities in the planning stages. First, we are evaluating our process for reviewing and approving applications for managed care contracts in order to identify potential problems with a plan's ability to meet contracting requirements before we approve the contracts. Second, we are redesigning our data system to facilitate cross-plan comparison of enrollments, disenrollments, appeals processing, complaints, quality and fiscal soundness in order to identify aberrant patterns that warrant investigation. Lastly, we have begun discussions with State insurance commissioners regarding actions that could be taken to coordinate activities. These include eliminating some duplicative oversight functions, and maximizing the sharing of information, especially with regard to plans experiencing financial difficulties. The importance of consistent and conscientious quality monitoring cannot be overemphasized, and I would like to devote the rest of my testimony to describing the progress that we have made in developing quality measurements and in fostering quality improvement.

QUALITY INITIATIVES

The argument for the potential of managed care to improve quality is well known. It starts with a critique of fee-for-service. Fee-for-service care tends to be fragmented with a focus on acute rather than preventive services. Economic incentives are in the direction of over-utilization of health care services. As a result, under fee-for-service, there tends to be an inappropriate and costly allocation of existing health care resources. It is then argued that the capitated prepayment made to managed care allows plans to organize care and re-allocate resources to address, in a coordinated and systematic way, the needs of each patient. In managed care, unlike fee-for-service, the organization is accountable for improving the well-being of the patient. This provides an opportunity, more elusive in fee-for-service, to improve the quality of care being furnished.

The flip side to the argument is also well known. In managed care, there is the potential for "under-service" and poor quality, if plans try to maximize short-term profits by not delivering appropriate care. The goals of our quality initiatives are to develop mechanisms to measure quality and to hold plans accountable for quality improvement. We have two approaches toward achieving these goals. The first approach is to use utilization data or encounter data to address "inputs" into the delivery of care. Most current performance measures are "process measures." Process measures refer to clinical interventions (tests, medications, procedures, surgery) which are believed to lead to favorable patient outcomes. While this approach has limitations, encounter data and process measures provide significant insight into the quality of care.

The second, and potentially the most efficient strategy for clinical performance measures, is to move toward outcome measures. The problem is that the science of outcomes measures is in its infancy. The movement towards better outcomes measures is critical for HCFA, like-minded purchasers, and beneficiaries in order to hold plans and providers accountable for the care they deliver. HCFA and the Agency for Health Care Policy Research (AHCPR) have been active in promoting research to identify these measures. With such measurements in hand, HCFA and the public will be able to objectively compare managed care to itself and to fee-for-service, and to determine whether managed care is living up to its potential to improve the quality of care. However, more research is needed, especially with regard to the health care needs of the poor, elderly, and other vulnerable populations, and with how to present this information effectively to beneficiaries.

As I indicated earlier in my testimony, a major focus of our efforts in recent years has been in working with our partners in the managed care industry and with other payers to accelerate and standardize the development of outcomes measures.

- **HEDIS 3.0**: The latest iteration of the Health Plan Employer Data and Information Set, HEDIS 3.0, reflects a joint effort of public and private purchasers, consumers, labor unions, health plans, and measurement experts, to develop a comprehensive set of measures for Medicare, Medicaid, and commercial populations enrolled in managed care plans. As of January 1, 1997, HCFA is requiring Medicare managed care plans to use HEDIS. This will facilitate comparison of plan performance measures and permit HCFA to hold plans accountable for the quality of the care they provide. HEDIS measures eight components including: effectiveness of care; access/availability of care; satisfaction with the experience of care; health plan stability; use of services; cost of care; informed health care choices; and health plan descriptive information.

  HCFA, working with the HEDIS Committee on Performance Management, was instrumental in adding functional status for enrollees over age 65 as a measure in the "effectiveness of care" category in HEDIS 3.0. This will be the first outcome measure in HEDIS that will longitudinally track and measure functional status. It addresses both physical and mental status through a self-administered instrument which determines whether the beneficiary perceives that his or her health status has improved, stayed the same, or deteriorated. In addition, six other measures that impact on Medicare beneficiaries have been added to the

"effectiveness of care" category, including: mammography rates, rate of influenza vaccination, use of retinal examinations for diabetics, outpatient follow-up after acute psychiatric hospitalization, and utilization of beta blocker in heart attack patients.

- **Foundation for Accountability**: The Foundation for Accountability (FAcct) is a new non-profit organization dedicated to helping purchasers and consumers obtain the information they need to make better decisions about their health care. As Federal Liaisons to the FAcct Board of Trustees, HCFA is joined by other public and private sector partners, including the American Association for Retired Persons, the Department of Defense, the Office of Personnel Management, Ameritech, and American Express. The underlying premise of FAcct is that better health care information, assembled from the consumers' point of view, should help steer Americans toward the highest quality care. Specifically, FAcct endorses and promotes a common set of patient-oriented measures of health care quality. Together, HCFA and AHCPR have played major roles in the development of FAcct quality measures for depression, breast cancer and diabetes. HCFA and the ASPE also recently contracted with the RAND Corporation, a non-profit research organization, to refine and test three sets of outcome measures for implementation in 1998.

- **Medicare Beneficiary Survey**: In cooperation with HCFA, AHCPR initiated the Consumer Assessment of Health Plans Study (CAHPS) to design a Medicare beneficiary survey. This survey quantifies Medicare enrollee responses about satisfaction with plan providers, access to services and providers, availability of services, and quality of care. Beginning January 1 of this year, HCFA is requiring all health plans to use CAHPS, which is now available to the public. HCFA plans to administer the survey through an objective single third party vendor in order to ensure comparability.

In addition to our quality measurement initiatives, we are actively involved in promoting quality improvement.

- **Projects to Assess Ambulatory Care in Managed Care Settings**: The Medicare Managed Care Quality Improvement Project (MMCQIP) is designed to enhance HCFA's ability to assess how well the ambulatory care process in managed care is meeting the needs of beneficiaries. At this time, we are evaluating the care received by Medicare managed care plan enrollees diagnosed with diabetes mellitus, and the incidence of screening mammography in a sample of enrolled beneficiaries. The PROs in five states (California, Florida, New York, Pennsylvania and Minnesota) and 23 Medicare-contracting HMOs are collaborating on MMCQIP. In addition, an on-going sister project, utilizing the PROs in Maryland, Iowa and Alabama, will analyze the same measures in the fee-for-service setting. The initial finding is that there is room for improvement in both managed care and fee-for-service in these two areas.

- **Medicare Choices Demonstration** - An important component of this demonstration is improvement in our comprehensive quality monitoring system. Under the Choices project,

we will be developing and testing quality/outcomes and risk adjustment measurements systems that use encounter data (health care services received by enrollees); all participating plans will be required to provide 100% encounter data. We have contracted with the RAND Corporation to assist us in designing such a system, which will be refined further using the "Choices" data.

Other important Medicare managed care quality initiatives include the establishment of new requirements for Medicare managed care plans in the areas of quality improvement activity; health information systems; health services management; and member rights and responsibilities. In addition, as part of a project to improve efficiency in monitoring and oversight, teams of HCFA and PRO staff are being formed to target a review of managed care plans' internal quality assessment and improvement programs; we have similar quality improvement initiatives for Medicare fee-for-service plans. Our budget also includes a provision to give us the authority to develop an integrated quality management system, so that we can assess more comprehensively the quality of care provided under fee-for-service.

THE PRESIDENT'S 1998 PROPOSALS

Everyone agrees that "knowledge is power," but at no time has the dissemination of information been so critical to health care choice. Beneficiaries are often stymied in their health plan choices by an overload of esoteric and confusing information, making it difficult to determine which plan best meets their needs. We seek to empower beneficiaries by ensuring wider and more consistent dissemination of health plan information in a format that is easier to understand.

The President's 1998 Budget Plan includes several proposals affecting areas I have already discussed. We believe these changes are important to achieve our stated goals of preserving the solvency of Medicare and enhancing beneficiary protections and choices. Specific actions we have taken to expand and enhance beneficiaries' choices include:

EXPANDING BENEFICIARY CHOICES

- **Expanded PPO/PSO Options** -- Currently, HCFA can contract with Federally qualified Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) to serve as Medicare managed care plans. The Administration believes that Medicare beneficiaries should have more managed care choices, comparable to those available in the private sector. Thus, the President's budget would expand managed care options to include Preferred Provider Organizations (PPOs) and Provider Sponsored Organizations (PSOs). We believe that direct contracts with alternative managed care models such as PSOs are the key to expanding managed care to rural areas.

The President's budget proposes that beneficiaries receive comparative materials on all of their coverage options -- both managed care and Medigap. To help beneficiaries compare various plans,

standardized packages for additional benefits offered by managed care plans and the Medigap plans would be developed. Medigap plans would be required to operate under the same rules followed by Medicare managed care plans. These Medigap reforms would require annual open enrollment, prohibit imposition of pre-existing condition exclusion periods, and prohibit differential premiums based on age or health status.

- **Annual Open Enrollment** -- Under Federal law, aged individuals have a once in a life-time opportunity to select the Medigap plan of their choice when they first join Medicare at age 65; individuals who become eligible for Medicare because of a disability or end-stage renal disease beneficiaries have no such choice. If a beneficiary enrolls in a managed care plan and is later dissatisfied, he or she may not have the opportunity to select the Medigap plan of his or her choice; for example, drug coverage may be unavailable due to the individual's poor health status. As a result, some beneficiaries are reluctant to try managed care or are fearful of being locked into managed care options with no opportunity to return to fee-for-service and Medigap. The President's budget gives all new beneficiaries, not just aged beneficiaries, the opportunity to choose the managed care or Medigap plan of their choice when they first enroll in Medicare. In addition, each year all Medigap and managed care plans will have to be open for a one month coordinated open enrollment period. Additional open enrollment opportunities will be available under certain circumstances -- such as, when a beneficiary's primary care physician leaves a plan or when a beneficiary moves into a new area.

- **Elimination of Pre-existing Condition Exclusions** -- In addition to addressing open enrollment, there are other Medigap reforms included in the President's budget. We would like to eliminate the ability of Medigap insurers to impose pre-existing condition exclusion periods. Under the policy in the President's budget, a Medigap plan cannot impose an exclusion period for a beneficiary who has recently enrolled in another Medigap plan, Medicare managed care, or employer-based plan. This is similar to the policy included in a bi-partisan bill introduced by Mrs. Johnson and others during the last session and we look forward to working together toward enactment this year.

- **Community Rating for Medigap Plans** -- Our final Medigap reform addresses rating. There are currently no federal requirements regarding the rating methodology used by Medigap plans. As a result, plans can use low premiums to entice beneficiaries to enroll in their fledgling stages, but as the company matures it raises the premiums to unaffordable levels. Under the President's budget, Medigap plans would be required to use community rating to establish premiums. The movement to community rating would be subject to a timetable and transition rules developed by the NAIC. Given that managed care plans are required to charge all enrollees the same premium, Medigap plans should not be allowed to charge differential premiums based on age. Also, if choice is an important goal, then premium structures such as attained age rating, which in effect make Medigap unaffordable as beneficiaries age, should not be allowed.

QUALITY INITIATIVES

- **Quality Measurement System**: The President's plan would authorize the Secretary to develop a system for quality measurement which would replace the current requirement that managed care plans maintain a "level of commercial enrollment at least equal to public program enrollment," which is often referred to as the "50/50 rule." In the interim, the Secretary could waive the 50/50 rule for plans in rural areas and for plans with good "track records"or in other instances the Secretary deems appropriate.

PRUDENT PURCHASING FOR MANAGED CARE PLANS

Through a series of policy changes, the Administration's plan would address the flaws in Medicare's current payment methodology for managed care. Specifically, the reforms would create a national floor to better assure that managed care products can be offered in low payment areas, which are predominantly rural communities. In addition, the proposal includes a blended payment methodology, which combined with the national minimum floor of $350 per member per month, would dramatically reduce geographical variations in current payment rates. The plan would reduce reimbursement to managed care plans by approximately $34 billion over 5 years. An assessment of the impact of the President's Medicare managed care proposals should consider the plan as a whole -- both the merits of the components that have a budget impact as well as other non-budget components, some of which were discussed above. It should also be kept in mind that Medicare per capita costs, upon which managed care payments are based, have grown over the past two years by approximately 16 percent, while growth in payments to plans on the commercial side have been virtually flat.

Proposals With A Budget Impact

- **IME/GME/DSH CARVE-OUT** (Five-year saving ---$10 billion): Payments for indirect medical education (IME), graduate medical education (GME), and disproportionate share payments (DSH) would be carved out of the blended payment rates over a two-year period (50 percent in 1998; 100 percent thereafter) and provided directly to teaching and disproportionate share hospitals for managed care enrollees and to entities with recognized teaching programs. The carve-out of these payments does not represent a reduction in payment for managed care enrollees because these funds would be provided to teaching and disproportionate hospitals directly by HCFA for such enrollees.

  - Managed care plans can consider these funds available to such hospitals when they negotiate their rates.

  - A current law provision that requires non-contracting hospitals to accept the Medicare diagnosis-related groups (DRGs) amount as payment in full would be modified to require non-contracting hospitals to accept the DRG amount, minus the carve-out, as payment in full.

- **INDIRECT IMPACT OF FEE-FOR-SERVICE PROPOSALS** (Five-year saving ---$18 billion). The budget proposes an update mechanism tied to overall Medicare growth. Therefore, policies that would affect fee-for-service providers would also restrain the growth of managed care payments.

- **FAVORABLE SELECTION ADJUSTMENT** (Five-year savings --- $6 billion): Beginning in 2000, an adjustment would be made to payment rates to reduce Medicare's current overpayment, which results from managed care enrollees being, on average, healthier than beneficiaries who remain in fee-for-service. Research studies support basing payments on 90 percent of the AAPCC rather than 95 percent, to take into account this phenomenon referred to as "favorable selection." This adjustment would remain in place until a new health status adjusted payment methodology is implemented.

  - Some have argued that the extent of favorable selection documented by Mathematica Policy Research (MPR) in 1993 no longer exists. This perspective, however, is not supported by a recent HCFA study (HCFA Review, Summer 1996), which would justify payment at 87.6 percent of the AAPCC, or about 83 percent if we continue to pay managed care plans five percentage points less than fee-for-service.

  - In the last three years, the Medicare program has lost, at a minimum, $2.2 billion because of favorable selection into managed care plans, and over $1 billion in the last year alone.

  - HCFA is developing a new payment methodology that incorporates health status adjusters and that moves away from the current policy of ignoring differences in utilization between managed care and fee-for-service in making payment to managed care plans. A proposal could be ready for Congressional action as early as 1999, with phase-in beginning as early as 2001. Payment at the 90 percent level would be consistent with payment levels anticipated under this new payment methodology.

  - Competitive Pricing Demonstration - This demonstration will test a new market-based payment methodology as a possible alternative to the AAPCC method, in addition to offering new education and information resources to local beneficiaries. The Denver site will start in 1997, to be followed by two additional sites.

Proposals Without A Budget Impact

- **BLENDED RATE METHODOLOGY** - The budget would dramatically reduce the current wide geographic variation in payment rates to managed care plans by breaking the link between plan payments and local fee-for-service experience. The blended payment rates, minimum payment and minimum increase would be implemented on a budget-neutral basis.

- **Impact on Relatively Low Payment Areas** - Managed care plans, now in relatively low payment counties, would benefit from the proposed blended payment rate. By 2002, 30 percent of their payment rate would be based on a higher national rate. In each year between 1998 and 2002, many of these plans would receive a "double update," with rates increasing due to both the national update and the transition to the 70/30 blend.

- **Impact of Minimum Payment Amounts** - The President's plan would create, for the first time, a national minimum payment amount which would significantly increase rates in isolated rural counties and could increase the number of managed care plans serving rural and other low payment areas, especially with the entry of Provider Sponsored Organizations (PSOs) into the Medicare program.

We have a few illustrations of the effects of our managed care payment reforms on rates in counties with various characteristics. As you can see, the impact on a particular county depends both on current teaching costs and on whether the county is currently receiving a relatively low or high payment. **[CHART #1]** The methodology would ensure that no county would receive a decrease during the 5 year budget window except in the year 2000. In 2000, almost two-thirds of counties (64%) would receive increases; the other counties would receive either no increase or a decrease no greater than 3.37%.

The net effect of the President's payment proposals is a balanced approach that achieves savings and significantly reduces current wide geographic variation **[CHART #2]**, while continuing the trend of increased enrollment in managed care. Our actuaries project that the combined effect of the managed care reforms, both the proposals with a budget impact and those without budget impact described earlier, would result in increases in managed care enrollment compared with present law. By fiscal year 2002, under the President's plan, 22.5 % of Medicare beneficiaries would be enrolled in managed care plans, compared to 19.3% under current law. **[CHART #3]**

CONCLUSION

We are aware that there is still much work to do in the area of quality improvement of managed care. As the managed care market further expands and evolves, we expect to reap the benefits of innovative payment, administrative and patient care strategies. Some of these have already been applied to our Medicare modernization efforts and will contribute to Medicare savings. We would like to expand the choices available to beneficiaries; enhance consumer protections; provide comparative information to assist beneficiaries in making health care choices; and reform the payment methodology to plans. These goals are shared by all with a commitment to consumer protection and there is certainly a consensus that quality and availability of health care is our number one priority. In cooperation with Congress, the health care industry, and the research community, we will reach our goals --- to extend the solvency of Medicare, and guarantee its existence for future generations of Americans. I look forward to working with you to accomplish these goals.